

nine year period. *Sex Transm Inf* 1999;**75**: 340–3.

- 9 **Kilmarx PH**, Palanuvej T, Limpakarnjanarat K, *et al*. Seroprevalence of HIV among female sex workers in Bangkok: evidence of ongoing infection risk after the "100% condom program" was implemented. *J Acquir Immune Def Syndr* 1999;**21**:313–6.
- 10 **Miles A**. *The sex industry legal kit for service providers and regulators*. New South Wales:

compiled by Sex Workers Outreach Project, 2000 (<http://www.swop.org.au/ressilk2.html>, accessed 14 February 2002)

- 11 **Johnson AM**, Mercer CH, Erens B, *et al*. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. *Lancet* 2001;**358**:1835–42.
- 12 **European Network for HIV/STD Prevention in prostitution (Europap/Tampep)**. *Hustling for health:*

developing services for sex workers in Europe. London: Imperial College, 1999.

- 13 **International Network of Sex Work Projects** (<http://www.walnet.org/nswp>)
- 14 **Lim LL**, ed. *The sex sector: the economic and social bases of prostitution in Southeast Asia*. Geneva: International Labour Organisation, 1998. See related press release (<http://www.ilo.org/public/english/bureau/inf/pr/1998/31.htm>, accessed 14 February 2002).

UK guidelines on STI

Revised UK national guidelines on sexually transmitted infections and closely related conditions 2002

M R FitzGerald, I Ahmed-Jushuf, K W Radcliffe, G Rooney, J Welch, JD Wilson

Updating and improvements continue

This month sees the final ratification of the revised UK national specialty guidelines, first published in *Sexually Transmitted Infections* in 1999.¹ We trust they will continue to be widely used to underpin best practice in genitourinary medicine. They are available to all via the websites of the UK specialist organisations (www.mssvd.org.uk and www.agum.org.uk) and are also on the database of the Royal College of Physicians Clinical Effectiveness and Evaluation Unit (CEEU) (www.rpclondon.ac.uk/college/ceeu/ceeu_guidelinesdb.asp) and the National Guidelines Clearing House, Washington (www.guidelines.gov). The guidelines are commissioned by the Clinical Effectiveness Group (CEG), set up jointly by the Medical Society for the Study of Venereal Diseases and the Association for Genitourinary Medicine. The revision process commenced in 2000 with authors being invited to modify and update their 1999 guidelines. These revised versions were posted on the website for a 3 month period and comments invited. The CEG and the authors concerned considered all suggestions and agreed any modifications to be made. The major considerations throughout were clarity and support by published evidence. The successful outcome is a tribute to collaboration within the specialty as a whole but we are particularly grateful to the authors, writing groups, and webmasters for generously giving their time and expertise. The substantive changes are listed below. There have also been minor changes to the wording of most guidelines to make them clearer.

URETHRITIS Chlamydia

Guidance is given on use of enzyme linked immunoassay tests (EIA) indicating that indeterminate results should be confirmed by a nucleic acid amplification test and that EIAs are not suitable for rectal or pharyngeal testing. The value of health advisers in partner notification is emphasised.

Non-gonococcal urethritis (NGU)

More specific data are given on the role of ureaplasmas and *Mycoplasma genitalium* in aetiology, now stated to cause 10–20% of acute cases and to be important in chronic NGU. It is suggested that partner notification information is obtained at the initial clinic visit and that follow up after treatment requires microscopy only if the patient has symptoms or signs of discharge.

Gonorrhoea

Increasing evidence of resistance to ciprofloxacin is noted, but it is still recommended as first line therapy; there have been no clinical trials of new licensed antigonococcal agents in the past 2 years.

VAGINAL DISCHARGE Bacterial vaginosis (BV)

A variety of criteria for microscopic diagnosis are given. Further findings on the association between BV and preterm labour are reviewed with the conclusion that current evidence still does not support routine screening and treatment. Screening and treatment of BV

before termination of pregnancy is recommended. One study has shown an association between BV and NGU in the male partner.

Candidiasis

The references and grading of evidence have been updated.

Trichomoniasis

The section on regimens for use in treatment failure has been altered. The references have been updated, including one linking trichomoniasis with transmission of HIV.

GENITAL ULCERATION

Genital herpes (GH)

Data are given on the sensitivity and specificity of type specific serology and the use of these tests in diagnostic and screening (pregnancy) settings. For pregnancy, there is a reminder that aciclovir is unlicensed although considerable support for its use exists. For GH in late pregnancy the importance of trying to establish whether the episode is a first one is emphasised. There is a more detailed discussion of the role and content of counselling, and more data on natural history. The Tzanck test is removed from diagnostic techniques.

Early syphilis

There is now a description of the differential diagnosis of the primary lesion, and of non-syphilitic causes of positive treponemal serology. The use of EIA and PCR tests in diagnosis and screening is discussed. Regular screening for syphilis is recommended when there is an outbreak. For penicillin treatment the recommended duration is shortened to 10 days. Instructions are given on Jenacillin as a source of procaine penicillin. For non-penicillin treatments, tetracycline is no longer recommended, the use of doxycycline is discussed more fully, and more data are given on experience with ceftriaxone and azithromycin. Treatment regimens are suggested for incubating syphilis and for epidemiological treatment. In pregnancy it is recommended that there is no need to retreat women for syphilis already treated in a previous pregnancy. In congenital cases follow up should be for

a minimum of 1 year, and the importance of screening siblings and parents in cases diagnosed after infancy is emphasised. Auditable outcome measures now include figures for the outcome of treatment and contact tracing.

Late syphilis

Tests and treatments are altered as for early syphilis. Penicillin regimens are shortened from 17–21 days to 17 days. All drug regimens are also now tabulated at the end of the guideline and there are appendices on penicillin desensitisation and skin testing. Physical examination in cases of late syphilis is outlined. There are suggestions on the use of TPHA tests on CSF in diagnosing neurosyphilis. In patients who do not have a CSF examination, treatment need not necessarily be as for neurosyphilis. Benzyl penicillin is described as being able to prevent progression to neurosyphilis despite not usually producing treponemicidal levels in CSF.

Donovanosis (granuloma inguinale)

The causative organism has been redesignated *Klebsiella granulomatis*. Encouraging results with azithromycin are highlighted.

Lymphogranuloma venereum

Few new data here because of its continuing rarity in industrialised countries; molecular diagnostic tests have now been used successfully.

Chancroid

Diagnostic methods have been updated to include reports on molecular techniques. Single dose ciprofloxacin is now thought to be an effective treatment in HIV positive individuals.

SYSTEMIC PRESENTATIONS AND COMPLICATIONS

Prostatitis

The guidelines point out that the lower urinary tract localisation procedure is not often used in a clinical practice, and even when used it may not alter patient management. Data are given on studies of terazosin and quercetin in chronic prostatitis syndromes. The National Institutes for Health chronic prostatitis symptom index is suggested as an outcome measure.

Epididymo-orchitis

Behçet's disease and amiodarone are now included in the aetiology. For cases caused by enteric organisms, ciprofloxacin has been added to the recommended treatment.

Pelvic infection and perihepatitis

More evidence is given for recommended treatment regimens and clarification of which regimens are suitable for out-patient and inpatient use. Some discussion of whether to remove intrauterine contraceptive devices in severe PID.

Hepatitis A, B, and C

Active research continues in this field and there are many changes in epidemiology and treatment. *Hepatitis A*: vaccination is now recommended for homosexual men under specific circumstances—that is, in areas of high prevalence among the homosexual population, such as central London. *Hepatitis B*: guidelines on treatment have been updated including information on new agents; flow charts are shown for the use of anti-HBc and HBs antibodies when screening. New information is given about the efficacy of hepatitis B vaccine with recommendations that boosters may not be required for 15 years after successful vaccination. *Hepatitis C*: many changes, including updated information on diagnosis, prognosis, and treatment.

Sexually acquired reactive arthritis

No significant changes to aetiology, clinical features, or diagnosis. Latest data are given on use of antibiotic therapy, with recommendations unchanged. Updated information given on treatment in pregnancy and breastfeeding. Some new details given on the role of intra-articular steroids and on effects of sulphasalazine.

MISCELLANEOUS

Anogenital warts

The extent of subclinical wart virus infection is emphasised. Presentations listed now include bleeding from anus and urethra, and distorted urinary flow. On management, the evidence base to compare and choose treatments is acknowledged to be weak; some agents are commonly used outside their licensed indications. 5-Fluorouracil is no longer recommended for meatal warts. Podophyllin is no longer recommended for internal lesions, and is felt to have inferior efficacy to podophyllotoxin; it has a theoretical risk of oncogenicity but it is noted that this has not been observed in humans.

Molluscum contagiosum, scabies

Changes in some references only.

Pediculosis

No changes.

Sexual assault

References updated.

Balanitis

References updated.

THE FUTURE

These guidelines are not a culmination but one step in a continuing process. The CEG is happy to receive comments and suggestions supported by appropriate references at any time, and will review them with the authors of the next revision. By this stage there will have been changes in the way in which the guidelines are developed. The Royal College of Physicians via its CEEU has recently endorsed the Appraisal of Guideline Research and Evaluation (AGREE) instrument² as its framework for assessing guidelines. It covers the scope and purpose of the guidelines, stakeholder involvement, rigour of development, clarity and presentation, applicability, and editorial independence. The CEG will use this instrument in future. We also intend to keep abreast of and apply any developments in knowledge about what makes guidelines effective in modifying medical practice, a crucial issue and one which is still strikingly under-researched.

The current guidelines provide a considered summary of the evidence in each area. They are not a set of instructions but rather are a useful tool to apply to the infinite range of clinical presentations our patients provide us with. They are written for UK clinicians having at their disposal the full range of diagnostic methods and treatments of GUM clinics. If the intentions of the sexual health strategy³ come about then an increasing amount of sexual health care will be done in general practice. This may require a very different set of guidelines in the future, and the work of a wider group.

Sex Transm Infect 2002;**78**:81–82

Authors' affiliations

M R FitzGerald, Genitourinary Medicine Department, Musgrove Park Hospital, Taunton, Somerset TA1 5DA, UK
I Ahmed-Jushuf, Nottingham City Hospital
K W Radcliffe, Whittall Street Clinic, Birmingham
G Rooney, Princess Margaret Hospital, Swindon
J Welch, King's College Hospital, London
J D Wilson, Leeds General Infirmary

Correspondence to: Dr FitzGerald; med@ist.nhs.uk

REFERENCES

- 1 **K Radcliffe**, I Ahmed-Jushuf, F Cowan, *et al.* 1999 UK national guidelines on sexually transmitted infections and closely related conditions. *Sex Transm Inf* 1999;**75**(suppl 1).
- 2 **The Agree Collaboration**. Appraisal of guidelines for research and evaluation (AGREE) instrument. www.agreecollaboration.org
- 3 *The national strategy for sexual health and HIV*. July 2001: www.doh.gov.uk/jointunit/jip.htm